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Legislative Audit Council

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Legislative Audit Council
Sunset Review of the
Board of Medical Examiners
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THE STATE OF SOUTH CAROLINA

GENERAL ASSEMBLY

LEGISLATIVE AUDIT COUNCIL

SUNSET REVIEW OF THE

BOARD OF MEDICAL EXAMINERS

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REPORT SUMMARY

Act 608 of 1978 mandates the establishment of "... A system for the Review, Termination, Continuation or Reestablishment of State Agencies, Boards, Departments and Commission." This is commonly referred to as the "sunset" act. Under this section of the law the General Assembly has set up a process for the "systematic review" of certain governmental entities so that it might be in a "better position to evaluate the need for their continuation, reorganization or termination." Section 6 of the Act lists 40 agencies, boards and commissions which are to be reviewed and sets termination dates for these entities. The South Carolina Board of Medical Examiners is scheduled to terminate on June 30, 1981.

The Board of Medical Examiners is the State agency responsible for licensing medical doctors, osteopathic physicians and physician assistants. It determines the qualifications that physicians must have in order to be licensed and enforces State statutes governing the medical and ethical conduct of physicians. Through these actions the public is protected from unscrupulous, unqualified or incompetent medical practitioners.

During the review of the Board of Medical Examiners, the Audit Council found several areas where improvements are needed. They are as follows:

- The standards that prospective physicians must meet in order to pass the Federal Licensing Examination (FLEX) are set in the Board's written rules and regulations. In actual practice, however, the Board's practices sometimes differ from its

formal regulations. The Board should set clear and consistent standards for passing the FLEX (see p. 14).

- The Board's rules and regulations narrowly define the role of physician assistants and restrict the duties they are allowed to perform. Other states are not as restrictive in their regulation of physician assistants and the use of mid-level practitioners is a growing trend nationwide. The Board should reexamine its regulation of physician assistants to allow them to better serve the medically needy areas of the State (see p. 18).

- The Board should increase its ability to investigate complaints in a timely manner. The Board employs two investigators. The conduct of investigations is six to nine months behind schedule. It is in the public's interest to investigate complaints quickly and completely (see p. 24).

- The Board should have guidelines upon which to base its disciplinary decisions. While a disciplinary decision must be based on the individual merits of each case, there is a need for guidelines governing the range of sanctions to be used for various violations of the Medical Practice Act (see p. 25).

- By statute, information concerning investigations, complaints and disciplinary actions taken by the Board are not communicated to other medical boards or enforcement agencies until final

action is taken. Because of the very nature of the practice of medicine, complaints and investigations often involve several agencies. Current laws impede the ability of these agencies to work together to resolve complaints and investigations (see p. 29).

- Currently, the Board is not able to require that hospitals and medical societies report disciplinary actions taken against staff or members for severe violations or incompetency. Since often the first sign that a physician is incompetent is when his hospital staff privileges are suspended or restricted, the Board should have the authority to ensure it will have access to this information (see p. 31).

- The Council reviewed Board members' travel and per diem expenditures for the 18 month period of July 1978 - December 1979 totaling approximately $49,350. The Board's policies concerning the collection of per diem and travel are very broad and in need of revision. State guidelines and regulations concerning the use of per diem by State Boards and Commissions need to be developed (see p. 32).

- The Board has no public members and the public does not attend Board meetings. To ensure that the public has input into the regulation of the profession public members should be added to the Board and the Disciplinary Commission (see p. 35).

- The Council found several areas of the Board's administration that needs improvement including inventory control and accounting of shared costs with the Board of Dentistry (see p. 36).

Overall, the Council found the Board to be performing adequately its regulatory functions of licensure, examination, complaint handling and disciplinary action. The areas noted for improvement will enable the Board to carry out more effectively its regulatory duties and will help ensure protection for the public's health, safety and welfare.

In performing this audit, the Council examined Board files, records and memos. Interviews were held with Board members, staff, officials from other State agencies, health associations and several health professionals. The Council attended a Board meeting and examined Board policies, procedures and statutes. The following report is divided into two sections; Board Review and Sunset Issues and Evaluation.

BOARD REVIEW

History and Background

Formal regulation of the medical profession did not begin in South Carolina until the Nineteenth Century. In the 1890's, county boards had regulatory authority over local physicians. The forerunner of the present State Board of Medical Examiners was created in 1920 with authority over not only medical doctors but nurses, chiropractors, naturopaths and other health-related professions as well. The other health professions formed their own Boards in the 1930's, and in 1969 by Act 433, the South Carolina Board of Medical Examiners became a composite Board for both medicine and osteopathy.

In 1975, the Board was given responsibility for licensing and examining physician assistants. Physician assistants are paramedical staff who assist the doctor in routine functions and can perform certain medical tasks under a doctor's supervision. As of September 1979, there were 3,750 medical doctors, 34 osteopathic doctors, and 54 physician assistants licensed in the State.

The duties of the Board as defined in current statutes are to "adopt rules and regulations for its government, for the practice of medicine and for the practice of osteopathy, for judging the professional and ethical competence of physicians and surgeons including a code of medical ethics, and for the discipline of physicians and surgeons (medical and osteopathic)." These duties are primarily carried out within four major activities: examination, licensure, investigation of complaints, and disciplinary hearings.

The Board is composed of eight doctors of medicine and one doctor of osteopathy. One medical doctor is selected from each of the six Congressional Districts and two from the State at-large. They are nominated by the South Carolina Medical Association (SCMA) and appointed by the Governor. The doctor of osteopathy is nominated by the South Carolina Association of Osteopathy from the State at-large and appointed by the Governor.

In addition, the Board of Medical Examiners is assisted by an 18 member Disciplinary Commission composed of licensed physicians, three from each of the six Congressional Districts, who are nominated by the SCMA and appointed by the Board. The Board selects a panel of three commission members to hold hearings on formal complaints. The confidential transcript of the panel hearing, with a recommendation, is turned over to the Board for a final disciplinary order.

The Board has created a liaison committee to work with the South Carolina Academy of Physician Assistants Association in developing regulations and procedures and to aid communication between the two groups. The Board also has formed a liaison committee with other health care groups such as nurses to develop nurse practitioner protocols.

Budget and Staff

The Board currently employs an Executive Director and a staff of seven full-time and three part-time positions. This includes two investigators who investigate complaints for the Board; two part-time law clerks and a part-time accountant. The other staff members perform all the Board's clerical and administrative tasks including publishing an

annual Medical Directory. Attorneys from the Office of the Attorney General are appointed to advise and assist the Board during disciplinary hearings and on other legal matters.

Employees of the Medical Board also perform all administrative and investigative functions of the South Carolina Board of Dentistry. The Medical Board pays full salaries of five employees and shares the cost of the other six employees with the Dentistry Board.

The largest source of Board revenue is the annual reregistration fee required from licensed doctors. Fees from doctors licensed in another State seeking reciprocity in South Carolina account for the Board's next largest source of income. In FY 78-79, total revenues collected were $256,536 and total Board expenditures were $244,933. Board expenditures have increased 52% over the past five years while revenues have increased 37% (see Table 1).

The Board is headquartered in downtown Columbia and shares its offices with the Board of Dentistry. Offices are rented from the Board's Executive Director, who is the owner of the building. This arrangement has been approved by the Division of General Services and the Board.

TABLE 1

SOUTH CAROLINA BOARD OF MEDICAL EXAMINERS

Statement of Revenue, Expenditures and Appropriations
Five-Year Period Ended June 30, 1980

	1975-76	1976-77	1977-78	1978-79	1979-80 (Estimated)
Revenue Generated					
Endorsement (Reciprocity) Fees	$ 41,900	$ 58,850	$ 70,750	$ 78,150	$ 88,800
Examination Fees	16,085	12,390	8,165	11,010	9,780
Certification Fees	1,120	3,160	1,080	1,200	2,085
Temporary License Fees	5,730	4,800	6,750	7,850	7,010
Reregistration Fees	86,430	114,700	157,515	143,625	192,190
Directory Sales	4,834	5,545	-	14,701	10,560
Late Charges & Miscellaneous	2,306	985	8,265	-	9,860
Balance From Previous Year	38,379	*	*	*	*
Total Revenue	$196,784	$200,430	$252,525	$256,536	$320,285
Expenditures					
Personal Service	$ 35,200	$ 39,757	$ 83,994	$112,035	$132,585
Per Diem	17,600	17,350	21,980	22,960	26,190
Travel	10,859	5,160	10,047	18,232	20,235
Telephone	1,259	2,265	2,286	1,781	3,000
Printing, Binding & Advertising	13,262	8,397	11,843	14,034	12,000
Repairs	236	669	1,442	1,851	1,000
Utilities	613	1,084	1,559	1,868	2,250
Postage	4,615	5,247	7,130	9,461	11,000
Examination Expenses	12,102	6,931	2,388	-	-
Professional Services	704	-	2,200	8,069	11,000
Office & Other Supplies	1,662	2,875	4,989	8,161	7,800
Rents	2,642	2,706	3,682	3,785	5,663
Data Processing	-	-	13,525	6,198	8,000
Equipment	4,141	5,802	7,502	6,434	-
Dues and Membership Fees	200	200	205	500	250
Motor Vehicle & Equipment	-	-	4,471	6,180	-
Insurance	234	621	655	868	1,200
In-Service Training	-	75	155	1,015	500
Employer Contributions	3,813	-	12,618	17,546	23,516
Other	5,443	-	2,377	3,955	3,000
Investigation Expense	62,450	25,582	10,963	-	-
Total Expenditures	$177,035	$124,721	$206,011	$244,933	$269,189
State Appropriations		$141,166	$233,148	$250,672	$269,189

Source: South Carolina Budget and Control Board

* In 1976 the Board came under the Comptroller General and these balances went into the General Fund.

Licensure

Sections 40-47-90 and 40-47-120 of the 1976 Code of Laws, and Board Regulation 81-80, list the following qualifications an individual must meet before he or she can be licensed as a medical doctor:

1. be a graduate of a medical school in the United States or Canada, approved by the American Medical Association (AMA), or a foreign graduate with the Education Commission for Foreign Medical Graduates (ECFMG);
2. pass an examination approved by the Board;
3. complete at least one year of approved post-graduate training;
4. complete the Board's application, furnish letters from three references and pay all required fees;
5. be a United States citizen or sign a Declaration of Intention; and
6. give evidence of good moral character and sobriety.

In addition, it is the Board's policy that candidates for the exam and for reciprocity must have a personal interview with a Board member.

The number of licensed physicians in South Carolina has grown steadily over the past five years, showing an increase of 22% (see Table 2).

TABLE 2

PHYSICIANS LICENSED AND REREGISTERED 1975-1979

	1975	1976	1977	1978	1979
Reregistration Practicing In-State	2,909	3,150	3,250	3,550	3,750
Reregistration Practicing Out-of-State	1,335	1,389	1,626	1,673	1,657
New Licenses Issued	400	510	463	480	514
Temporary and Limited Licenses Issued	366	401	544	484	645

Examination and licensure of osteopathic physicians follows the same procedure as that for other doctors. The two branches of medicine are very similar. Osteopathic physicians use manipulation of the skeletal-muscular structure to cure disease or pain as well as medicines and surgery. They receive the same amount and basically the same type of training as do medical doctors, with the exception that they must hold a degree from an osteopathic school approved by the American Osteopathic Association.

The Board issues temporary and limited licenses to physicians under certain conditions. A doctor seeking reciprocity receives a temporary license allowing him to work in South Carolina while the Board is processing his application. Temporary licenses are also issued to recent medical school graduates who have passed the Board approved exams and are completing their post-graduate requirements. The Board issues limited certificates which restrict a doctor from working outside a supervised setting and do not allow the doctor to write prescriptions for narcotics.

Some Licensure Requirements Not Needed

The Audit Council has examined the Board's regulations for licensure and found several to be unnecessary. The Board's requirement that foreign doctors sign a Declaration of Intention (which begins the process of applying for United States citizenship) is not needed. The Board places doctors who have fulfilled all requirements except that of signing a Declaration of Intention on a "permanent/ temporary" status. Physicians with permanent/temporary licenses have all the privileges of doctors who are United States citizens. Board records show that currently there are 129 doctors with permanent/temporary licenses. Other states, Georgia for example, have repealed all citizenship requirements. If a physician can meet all the Board's educational and professional requirements, there should be no other barriers to full licensure. This requirement is not needed to protect the public and, in fact, only serves to create more paperwork for the Board's staff.

According to Board policy, candidates who have taken the Federal Licensing Examination (FLEX) and candidates for reciprocity must be interviewed by a Board member before they can be licensed permanently. The purpose of the interview is to allow the Board to review personally candidates' credentials, and to discuss with them where they intend to locate and what type of specialty they will practice. This type of personal interview is not necessary except under special circumstances. Board staff already verify and check licensure applicants' credentials, and data on the location and type of physicians in the State are collected and computerized by the South Carolina Cooperative Health Statistics System. Once a candidate meets the Board's educational, professional and ethical standards, there should be no other requirement for licensure.

Individual interviews with Board members may mean an out-of-town trip for the candidate and extra work for the Board and their staff.

RECOMMENDATIONS

THE BOARD SHOULD RESCIND ITS REGULATION THAT A PHYSICIAN MUST BE A UNITED STATES CITIZEN OR SIGN A DECLARATION OF INTENTION IN ORDER TO BE FULLY LICENSED IN SOUTH CAROLINA.

THE BOARD SHOULD REVISE ITS POLICY AND ONLY INTERVIEW CANDIDATES FOR LICENSURE WHEN SPECIAL CIRCUMSTANCES ARISE.

Examination Process

Two national medical exams are recognized by the Board: the Federal Licensing Examination (FLEX) sponsored by the Federation of State Medical Boards (to which every State Board belongs); and the National Board examination created by the National Board of Medical Examiners. The National Board is composed of medical educators throughout the United States with headquarters in Philadelphia, Pennsylvania. The two exams are written, multiple choice tests consisting of three day-long sessions.

The Board administers only the FLEX, which is given in June and December every year. The National Boards are administered by the medical schools and are given at different periods during the course of

a doctor's training. For example, Part I of the National Boards is given after the sophomore year of medical school; Part II is given before graduation, and Part III is taken after six months of post-graduate training. Most medical schools require passage of Parts I and II of the National Boards before a student can graduate; therefore, most medical school graduates opt for the National Boards and do not take the FLEX. The Board administers the FLEX only to those who have not been able to take or to complete the National Boards, such as foreign medical school graduates.

Applicants are allowed to take the FLEX three times in South Carolina. If the exam is failed a third time, the applicant must receive another year of medical training before he or she is eligible to retake the FLEX. The failure rates for the June 1979 and December 1979 FLEX exam were 37% and 45% respectively. The average rate of failure for all FLEX exams administered by the Board since 1969 is 38.7%. The Board has administered exams to a total of 743 applicants in ten years.

In order to pass the FLEX in South Carolina, the Board requires that applicants achieve at least 70% on each of the three parts of the exam, with an overall weighted average of 75%. The FLEX tests on the basic sciences the first day, clinical sciences the second day, and clinical competence the third day. Scoring of the exam is weighted so that the first day counts one-sixth of the final score; the second day, two-sixths; and the third day, three-sixths. Many applicants who fail the FLEX exam, do so because they fail to achieve 70% in the basic sciences.

In interviews with the Audit Council, Board members have said that many candidates fail the basic sciences because this is studied in

the early years of medical school, and the FLEX is administered after graduation.

Consistent Examination Standards Needed

The standards that prospective physicians must meet in order to pass the FLEX examination are stated in the Board's written rules and regulations. In actual practice, however, the Board's practices sometimes differ from its formal regulations.

For instance, Board regulation 81-80 states that the "minimum standards of performance required on each examination shall be at least: a score of 70 on each subject, a score of 70% each day, and a FLEX weighted average of 75% for the examination. Unsuccessful candidates, within five points of a passing average, may retake the examination twice."

Review of examination scores for the last three years (1977-1979) shows that the Board passes candidates who fail to achieve a 70% in each individual subject but receive an overall average of 75%. The Board also has licensed some candidates who achieve less than 70% for Day I of the FLEX, stipulating that these candidates receive more post-graduate training or be certified in a specialty. Unsuccessful candidates who failed the exam by more than five points are allowed to retake the exam.

The Board has not changed its regulations to reflect its actual policies for passing the FLEX. In fact, its written regulations appear to be out-dated and should be revised. The requirement of a 70% score in each subject is not consistently followed by the Board and is not necessary. Likewise, the requirement that a 70% be achieved each day

to pass the FLEX is not a hard-and-fast rule. According to Board policy, if a candidate fails Day I of the FLEX, other factors will be considered in deciding whether to require a retaking of the exam. Other factors include the candidate's amount of post-graduate training, references and where he or she plans to practice.

The Board needs to set clear and consistent standards for passing the FLEX. If the current regulations are too strict, they should be changed, but the Board should follow written, formal regulations when applying examination standards in order to assure that each licensure candidate is measured against a standard criteria. The present practice could make it difficult for the Board to be objective in applying licensure standards and leave it open to criticism.

RECOMMENDATION

THE BOARD SHOULD CHANGE ITS FLEX REGULATIONS TO FOLLOW ACTUAL PRACTICE AND UNNECESSARY REQUIREMENTS SHOULD BE DROPPED.

Fees

The total operating cost for the Board is derived from State appropriations which are recouped by charging licensing and examination fees. The Board estimates the total fees collected in FY 79-80 to be $320,000.

TABLE 3

FEE SCHEDULE FOR FY 79-80

Examination Fees:	
Doctors	$185
Physician Assistants	$ 65
Reregistration Fees:	
Doctors	$ 30
Physician Assistants	$ 15
Temporary Licenses	$ 10
Limited Certificates	$ 40
Reciprocity	$150
Certification(1)	$ 20

(1) Certification fees are charged when a South Carolina doctor asks the Board to certify his credentials to another state examining board.

Reciprocity

The Board grants reciprocity to doctors licensed in other states provided their qualifications are equal to those required in South Carolina. Each doctor seeking reciprocity must show proof of a medical degree, an out-of-state license and that he or she has no pending disciplinary actions. Reciprocity applicants must furnish three references from physicians (preferably from South Carolina) and obtain a personal

interview with a Board member. During FY 78-79, 521 doctors applied for reciprocity in South Carolina.

The Board grants reciprocity to osteopathic physicians provided they have been licensed by another composite (i.e., medical and osteopathic) board or have passed the National Board of Osteopathic Examiners.

Licensure of Physician Assistants

Physician assistants are a relatively new profession and have been licensed in South Carolina since 1975. To be licensed by the Board, a prospective physician assistant must be a high school graduate and a graduate of an approved program. The Medical University of South Carolina has the only Board approved physician assistant program in the State. It is a two-year program with both clinical and classroom instruction. There is little standardization of physician assistant programs nationwide: some are a year or less in duration and others offer a complete B. S. degree with clinical training.

The Board requires physician assistants to pass a written test designed by the National Board and administered by the National Commission for Certification of Physician Assistants, which is based in Atlanta. The national test is given in Charleston every October. In addition, physician assistant's must pass a test on the South Carolina Medical Practice Act, given in June and December each year. Temporary licenses are issued so the physician assistant may work while he or she is waiting to take the exams. The failure rate for the Board exam has been an average of 7% for the 1978 and 1979 exams. Previously, the State exam covered scientific and clinical subjects and the failure rate

averaged 31%. In 1978, the Board changed its policy and only tests physican assistants on the Medical Practice Act.

Restrictions on Physician Assistants

Rules and regulations developed by the Board of Medical Examiners narrowly define the role of physician assistants and restrict the duties they are allowed to perform. Physician assistants are restricted to a Board list of 22 tasks. An assistant and his or her supervising physician may request to do additional procedures and must document to the Board any extra training. Physician assistants must appear before the Board whenever they wish to work under a different supervising physician. In order to be licensed, to request additional tasks, or any other change in their status, the physician assistant and supervising physician must make a personal appearance before the Board.

Board regulations forbid a physician assistant from performing "any task without the supervising physician being either physically present or immediately available." Subsequent Attorney General's opinions have defined the phrase "immediately available" to depend on the nature of the task being performed by the physician assistant. If the physician assistant is performing a task that requires no physical acts upon a patient, the physician is "immediately available" if he can be reached by telephone. If a physician assistant is to perform a procedure upon a patient, the physician must be exercising "immediate control."

State law provides that no one but a physician can "practice medicine," which basically means to diagnose and treat illnesses and injuries. Therefore, the Board has designed its regulations to remove

any independent judgment from physician assistants and to prevent them from practicing medicine.

In addition, the Board has placed stringent regulations upon physician assistants because, until recently, the length of training for physician assistants varied greatly from state to state. Programs can vary from one to four years in duration, and the Board is concerned that unqualified persons would be performing procedures upon patients. However, the Board has not set a minimum for the training and experience a physician assistant should have. It only mandates that a physician assistant complete an AMA-approved training program, pass the National Board exam, and have experience which is acceptable to the Board.

In recent years physician assistant training programs have been upgraded. The physician assistant program in South Carolina is a two-year course. Duke University offers a four-year degree with its physician assistant program. A study by the American Academy of Physician Assistants found that of those who graduated from physician assistant programs in 1976, 46.6% entered the programs with bachelor or master degrees; 13.7% with associate degrees and 24.85% with some college background. Also, physician assistants in South Carolina are nationally certified by taking National Board exams. To keep this certification, the National Commission on Certification requires them to earn 100 hours of continuing medical education every two years.

Restrictions on physician assistants in other states are not as severe. North Carolina, for example, defines physician "supervision" as "continuous availability of direct communications by radio, telephone or telecommunications." Other states, such as Florida, do not list the tasks physician assistants may do. It is up to the employing and supervising physician to decide what his assistant can or cannot do.

Increased utilization of mid-level professionals has been recommended by the State Health Systems Agencies and is recommended in the State Health Plan. One report compiled by the Palmetto-Lowcountry Health Systems Agency noted that a severe health manpower shortage exists in South Carolina, especially in rural areas. It said that increased utilization of physician assistants "would increase the productivity of the physician." It recommended that the Medical Board allow a doctor to employ two assistants and that under certain circumstances physician assistants be allowed to practice outside of immediate supervision.

Other mid-level medical personnel, such as nurse practitioners, are not regulated as strictly as the physician assistants. (Nurse practitioners are licensed by the Board of Nursing.) A nurse practitioner and his or her supervising physician develop a set of written "protocols" which allow the nurse practitioner to perform a wide variety of tasks.

Doctors interviewed said their physician assistants are a benefit to the public because patients can receive more health counseling and follow-up care while the doctor is freed to devote more time to the critically ill. One study published in the "Annal of Internal Medicine," September 1979, analyzed previous studies performed to assess the quality of care offered by mid-level practitioners. It concluded that a "physician assistant should be well accepted by patients and provide the average office patient with primary care that compares very favorably with care given by the physician."

The increased use of mid-level practitioners is a growing trend nationwide. This State, with a large underserved rural population, has a need for more mid-level health personnel who can "extend" the doctor's time. In fact, the HSA report found that of the physician assistants

who graduated from MUSC and were employed in South Carolina, 70% were serving in designated health manpower shortage areas.

RECOMMENDATIONS

THE BOARD OF MEDICAL EXAMINERS SHOULD REEXAMINE ITS RULES AND REGULATIONS CONCERNING PHYSICIAN ASSISTANTS. IT SHOULD DEVISE NEW REGULATIONS WHICH WOULD ALLOW PHYSICIAN ASSISTANTS TO BETTER SERVE THE MEDICALLY NEEDY AREAS IN THE STATE. ANY NEW REGULATIONS SHOULD BE DEVELOPED IN CONJUNCTION WITH THE HEALTH SYSTEMS AGENCIES, WITH INPUT FROM PHYSICIAN ASSISTANTS, THE MEDICAL UNIVERSITIES AND SUPERVISING PHYSICIANS.

THE BOARD SHOULD SET MINIMUM STANDARDS FOR THE EDUCATION AND TRAINING OF PHYSICIAN ASSISTANTS.

Complaints and Disciplinary Action

The Board receives complaints from several sources including the general public, physicians, other Boards and State agencies. In addition, the Board initiates complaints against physicians as a result of criminal and civil court actions. When a complaint is received, the complainant is sent a complaint form to be filled out and notarized. Upon receipt of the completed form, the complaint is forwarded to the Board President

who approves the request for investigation. The Council's review of complaint files found that all requests for investigation are approved.

The Board employs two investigators who look into all allegations, takes statements from witnesses, gathers hospital records, and other evidence. After gathering preliminary evidence, the investigator and the Board attorney advise the Board on the merits of the case. At this point, the Board may decide to dismiss the case for lack of cause or lack of evidence, or elect to proceed. When all evidence is collected, a status report on the case is made to the Board. The Board's Executive Director issues a formal complaint, sets a hearing date and notifies the physician in question of the charges and hearing date. At this point, the physician may respond in writing to the complaint.

After a formal complaint is authorized by the Board, the Director of the Board convenes a three-member disciplinary panel to hear the case. The panel for each case is chosen through a rotation method and is selected from the 18-member Disciplinary Commission. At the disciplinary panel hearing, testimony is taken, evidence is submitted, and arguments presented by both sides. Based upon the hearing, the panel issues its findings and recommendations to the full Board. The Board reviews the evidence and panel proceedings and hears final arguments from the attorneys. The Board reaches its decision and issues a final order to the physician. Board actions can range from private or public reprimand to probation, suspension for a specified time, indefinite suspension, or revocation.

Disciplinary action taken by the Board must be by majority vote of the membership and all decisions are subject to review by a Circuit

Court should the defendant so desire. Offenses which merit disciplinary action are listed in Section 40-47-200 of the 1976 South Carolina Code of Laws. Also, violations of the principles of medical ethics as stated in Article 6 of the Board's rules and regulations can result in disciplinary action.

The Audit Council reviewed 127 complaints (see Table 4) initiated from January 1977 throuth March 1980. Fifty-seven (45%) of these were public-initiated complaints and 70 (55%) were initiated by the Board. The complaints ranged from incompetence and unethical conduct to tax evasion.

TABLE 4

TYPE AND NUMBER OF COMPLAINTS BY COMPLAINTANT

1977 THROUGH MARCH 1980

Board Initiated Complaints		Public Initiated Complaints	
Type of Complaint	Number	Type of Complaint	Number
Drug Abuse	20	Incompetence	22
Unlicensed Person Practicing Medicine	12	Unethical Conduct	19
Unlawful Prescriptions	8	Unlicensed Person Practicing	7
Incompetence	7	Improper Prescribing	5
Improper Prescribing	5	Immoral Behavior	2
Fraud	3	Fraud	1
Unethical Conduct	3	Drug Abuse	1
Assault	2		57
Falsification of Application	2		
Miscellaneous	8		
	70		

TABLE 5

NUMBER OF COMPLAINTS FROM

JANUARY 1977 THROUGH MARCH 1980

1977	1978	1979	1980 (Through March)	TOTAL
20	36	56	15	127

The Audit Council noted several areas for improvement in the Board's complaint and disciplinary process. These areas are detailed below.

Need for Additional Investigative Capability

At present the Board does not have the ability to investigate fully complaints in a timely manner. The primary reason for this is the limited size of the investigative staff. The Board currently employs two investigators. As seen on Table 5, the number of complaints against physicians has risen rapidly in the past three years. These investigators must spend considerable time traveling to collect evidence, take statements and prepare work papers and other documentation.

The investigatory function of the Board is one of its most important duties. It is one of the few means of protection the public has after a physician has been licensed, and should receive the same consideration as the licensure function. According to the Board's investigator, the investigations are generally six to nine months behind schedule. Even though the Board has the power to issue a temporary restraining order against a physician suspected of violating the law, the ability to investigate a situation quickly and completely is the public's best protection.

RECOMMENDATION

THE BOARD SHOULD INCREASE ITS CAPABILITY TO INVESTIGATE COMPLAINTS. IN ORDER TO PERFORM THIS FUNCTION IN THE MOST ECONOMICAL FASHION, THE BOARD SHOULD COORDINATE ITS EFFORTS WITH THOSE OF OTHER MEDICALLY-ORIENTED BOARDS.

Need for Disciplinary Guidelines

The Board needs guidelines upon which to base its disciplinary decisions. The Audit Council examined the 31 final order cases from 1977 to 1980 and found that the final actions taken by the Board varied from case to case even though offenses were similar. The Council examined the recommendations of the disciplinary panel versus those of the Board (see Table 6). In some cases there was a disparity between the recommendation of the disciplinary panel and the final action taken by the Board. One reason for this is that the Board often has access to information not available to the panel. The Board promulgates standards of conduct and ethics and is quite specific as to how a physician should conduct him/herself. However, the Board does not have guidelines for sanctions or ranges of sanctions to be used in the event that an offense is committed.

While the Board should be allowed to base its decision on the individual merits of each case, there is a need for some minimal guidelines. A policy based on this consideration would be fair and judicial both from the standpoint of the Board and the accused. The present lack of guidelines in the disciplinary process could possibly inhibit the

effectiveness of Board sanctions. Guidelines would ensure that the public's interest is protected and guarantee that an offending physician will be subject to at least minimum penalties in retribution for violations of the Medical Practice Act.

RECOMMENDATION

THE BOARD SHOULD ESTABLISH GENERAL GUIDELINES GOVERNING THE RANGE OF SANCTIONS TO BE USED FOR VARIOUS VIOLATIONS OF THE MEDICAL PRACTICE ACT BUT CONTINUE TO BASE ITS DECISIONS ON THE MERITS OF EACH INDIVIDUAL CASE.

TABLE 6

ACTIONS TAKEN ON COMPLETED CASES

1977 THROUGH MARCH 1980*

OFFENSE	DISCIPLINARY PANEL RECOMMENDATION	FINAL BOARD ACTION
1. Unprofessional Conduct	Indefinite suspension	Indefinite suspension, stayed with probation
2. Assisting Unlicensed Practice	2 years' suspension, 6 mths' stay, 18 mths' probation	Same as panel
3. Assisting Unlicensed Practice	2 years' suspension, 3 mths' stay, 21 mths' probation	Same as panel
4. Crimes Involving Drugs	2 years' suspension, stayed with conditions	Indefinite suspension,stayed with conditions
5. Crimes Involving Drugs	Public reprimand	5 years' suspension, stayed after 2 mths
6. Crimes Involving Drugs, Unprofessional Conduct	Indefinite suspension	5 years' suspension, stayed with probation
7. Unprofessional Conduct	Private reprimand	1 year suspension, stayed with probation
8. Addiction, Unprofessional Conduct	Revocation	Indefinite suspension
9. Tax Evasion	Public reprimand	Same as panel
10. Fraud, Unprofessional Conduct	Public reprimand	Indefinite suspension, stayed
11. Addiction, Unprofessional Conduct	Indefinite suspension	Revocation
12. Unknown	Private reprimand	Private reprimand
13. Assisting Unlicensed Practice	Private reprimand, 1 year probation	Public reprimand, 1 year probation
14. Crimes Involving Drugs, Unprofessional Conduct	Indefinite suspension with conditions	Same as panel
15. Improper Drug Prescription	Private Reprimand	Same as panel
16. Unprofessional Conduct	Suspension for 60 days	Public reprimand
17. Fraud, Unprofessional Conduct	Public reprimand	3 mths' suspension, stayed with conditions
18. Crimes Involving Drugs	Indefinite suspension	Same as panel
19. Crimes Involving Moral Turpitude	3 years' suspension	Same as panel
20. Crimes Involving Drugs	Indefinite suspension, stayed	Indefinite suspension

OFFENSE	DISCIPLINARY PANEL RECOMMENDATION	FINAL BOARD ACTION
21. Crimes Involving Moral Turpitude	No action recommended	2 years' suspension, stayed
22. Conviction of Drug Crimes	Revocation of drug license	Indefinite suspension
23. Crimes Involving Drugs	Revocation	Indefinite suspension
24. Unprofessional Conduct	No hearing	Voluntary license surrender
25. Unprofessional Conduct, Drug Abuse	No hearing	Voluntary license surrender
26. Crimes Involving Drugs	Private reprimand	1 year suspension, stayed
27. Official Misconduct	Private reprimand	Public reprimand
28. Felony	No action	Indefinite suspension, stayed, under appeal
29. Drug Abuse	Private reprimand	Public reprimand
30. Drug Abuse	Private reprimand	Public reprimand
31. Conviction of Multiple Felonies	Revocation	Revocation

* Definitions:

Private Reprimand - A private admonition by Board which is held in confidentiality.

Public Reprimand - A public admonition by the Board of the physician. This action is publicized and information is available to the public.

Suspension - The withdrawing of a physician's license to practice for a definite or indefinite period of time.

Revocation - The permanent withdrawal of a physician's license to practice.

Source: Disciplinary records of the Board of Medical Examiners.

Need to Allow for the Transfer of Complaints Information

By statute, information concerning investigations, complaints and disciplinary actions taken by the Board are not communicated to other medical boards or enforcement agencies. Section 40-47-212 specifies that:

> Every communication, whether oral or written, made by or on behalf of any person, firm or corporation to the Board or any person designated by it to investigate or otherwise hear matters relating to the revocation, suspension or other restriction on a license or the limitation on or other discipline of a licensee, whether by way of complaint or testimony, shall be privileged; and no action or proceeding, civil or criminal, shall lie against any such person, firm or corporation by or on whose behalf such communication shall have been made by reason thereof, except upon proof that such communication was made with malice.

It appears that the intent of Section 40-47-212 is to protect the confidentiality of complainants and/or witnesses. However, as it is currently being interpreted by the courts, this Section prevents the release of any complaint or disciplinary information to other regulatory or enforcement agencies until final action is taken. Because of the very nature of the practice of medicine, it is quite likely that several agencies may become involved in major complaints and investigations. In cases related to drug abuse, State and local police, DHEC and the Board of Pharmacy may become involved. Likewise, cases involving the prescribing of drugs by a nurse, are likely to involve the Board of Nursing, the Board of Pharmacy and the Medical Examiners, if a physician sanctioned the nurse's actions. However, as the law states, the Board cannot release this information to other agencies. This causes several problems. By not allowing the free flow of information to other enforcement agencies the effectiveness of those agencies is reduced.

Also, the effectiveness of the Board itself is compromised because other agencies do not know what information may be of interest to the Board. However, the primary effect is upon the public. The longer an incompetent, unethical or unlicensed person remains in practice, the greater the chance of that person harming someone. In the long run, the current law may impede the process of halting such a person's practice.

RECOMMENDATION

SECTION 40-47-212 SHOULD BE AMENDED TO PERMIT THE EXCHANGE OF INVESTIGATION INFORMATION BETWEEN THE BOARD OF MEDICAL EXAMINERS AND THE FOLLOWING AGENCIES:

BOARD OF PHARMACEUTICAL EXAMINERS

BOARD OF NURSING

BOARD OF DENTISTRY

BOARD OF VETERINARY EXAMINERS

BOARD OF CHIROPRACTIC EXAMINERS

STATE LAW ENFORCEMENT DIVISION

DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL.

SUCH INFORMATION SHOULD REMAIN CONFIDENTIAL.

Board Needs Ability to Mandate Reporting of Disciplinary Actions

Currently, the Board is not able to require that hospitals and local medical societies report disciplinary actions taken against staff and members for severe violations or incompetency. In 1978, the Board asked hospitals to report major disciplinary actions to the Board. Although the Board's request was endorsed by the South Carolina Hospital Association, the Audit Council could find no indication that hospitals are cooperating fully with the request. The Board does not keep a separate file on hospital responses and complaint files indicate that only one investigation has been initiated as a result of a hospital reporting disciplinary actions to the Board.

Often the first sign a physician is incompetent or in violation of the law is when his hospital staff privileges are reduced or suspended. Similarly, local medical societies will censure or discipline their members. The Board needs to know about these actions in order to determine if a formal investigation and complaint is warranted. However, simply expecting hospitals and medical societies to comply voluntarily as opposed to mandating it by law, does not ensure the Board will receive this necessary information. Until the Board has at its disposal all information relating to possible physician violations or incompetency, it will be handicapped in its ability to protect the public.

RECOMMENDATION

THE MEDICAL PRACTICE ACT SHOULD BE AMENDED TO DIRECT HOSPITALS AND LOCAL MEDICAL SOCIETIES TO REPORT TO THE BOARD OF MEDICAL EXAMINERS WHEN AND UNDER WHAT

CIRCUMSTANCES THEY HAVE REVOKED, SUSPENDED, RESTRICTED OR REFUSED PRIVILEGES AND/OR MEMBERSHIP TO ANY PHYSICIAN DUE TO SERIOUS OFFENSES OR INCOMPETENCY.

Travel and Per Diem Expenditures

The Council reviewed Board members' travel and per diem vouchers for FY 78-79 and the first six months of FY 79-80 totaling approximately $49,359. The Council found the Board's policy concerning the collection of per diem and travel to be very broad and in need of revision. Additionally, improvement is needed in the documentation of travel and per diem payments.

The Board's policy regarding per diem differs from most agencies and regulatory boards in that per diem is paid for board-related work performed at a Board member's office in addition to regularly scheduled Board meetings. Travel and per diem is also paid for attendance at national and local professional association meetings which do not directly involve the Board's regulatory duties. These policy statements provided to the Council by the Board's director are as follows.

> It is the policy of the Board of Medical Examiners to reimburse Board members for their Board duties performed from their Congressional District, and statewide as well, which include various assigned interviews and various other interviews each week, discussions with local medical groups, hospital matters of concern to the Board, complaints, legal matters and numerous telephone calls in all of these areas. Each Board Member receives per diem for one day each week ($35 per day) for the Board business performed which is usually carried out on Fridays.

> Regarding Board member's attendance at national and local meetings, the Board feels that this enables them to enlarge their national understanding of medical affairs and practice; and when they are able to take time off from their busy schedule to attend such meetings, the Board approves requests of this nature. When highly qualified, active professionals serve on the Board and are certified in certain fields of medical practice, it is of much benefit for them to evaluate certain complaints in areas of their expertise rather than going to the expense of calling committees in these fields when qualified people can be found who are willing to serve and give up several days of their time to review volumns of patient charts.

One reason for these policies appears to be the Board's requirement that certain candidates for licensure be interviewed by a Board member. As discussed on page 11, this requirement is not necessary except in special circumstances. Another factor is the lack of specific State regulations and guidelines concerning per diem. State regulations concerning per diem reimbursements only specify who can receive per diem and the amount paid per day ($35). They do not provide guidance as to under what circumstances per diem should be received, how often it can be collected, or any other details or restrictions.

The Board's per diem expenditures exceed other regulatory Boards examined by the Council. For example, the seven-member Board of Nursing regulates over 20,000 nurses and has annual per diem expenses under $2,200. The nine-member Board of Accountancy annually tests over 600 candidates and had per diem expenditures of $3,990 in FY 78-79. The South Carolina Insurance Commission spent only $1,890 in per diem in FY 78-79. The nine-member Board of Medical Examiners' per diem expenditures were $21,770 for the same period (see Table 7). In other

State agencies, boards and commissions, it is the general practice of Board members to claim per diem in connection with travel which is directly related to Board business, such as official Board meetings and the examination of professional candidates.

TABLE 7

PER DIEM EXPENDITURES FOR 18 MONTH PERIOD

JULY 1978 - DECEMBER 1979

Board Members	Total Per Diem Reimbursements	Equivalent In Days
1	$ 4,375	125
2	3,570	102
3	5,635	161
4	3,535	101
5	3,290	94
6	3,045	87
7	3,640	104
8	3,045	87
9	2,590	74
Total	$32,725	935

In conclusion, there is a need for the Board to document fully travel and per diem expenditures and revise its current policies to be in line with the practices of other State agencies and boards. In addition, there is a need for additional State regulations and guidelines concerning the use of per diem and travel expenses.

RECOMMENDATION

THE STATE SHOULD PROMULGATE SPECIFIC REGULATIONS CONCERNING THE USE OF TRAVEL AND PER DIEM BY MEMBERS OF STATE BOARDS AND COMMISSIONS.

Continuing Education

Continuing education is not required by the Board as a basis for renewal of medical licenses. However, the Board, as a disciplinary measure, sometimes places a physician on probation with the stipulation that he or she obtain a certain amount of continuing education. The Board has recently implemented a new program designed to retrain doctors who, as a result of disciplinary measures, have been barred from practice for a period of time. The program is being administered in conjunction with the State's medical schools and involves academic and psychiatric testing of the doctors and a full-time training program of approximately six months.

The Board has appointed a committee to study the issue of continuing education as a requirement for maintaining a medical license. Currently, South Carolina is one of 26 states which do not mandate continuing education. Physician assistants in South Carolina, in order to maintain their national certification, are required to obtain 100 hours of continuing education every two years.

Public Participation

By law, all members of the Board and the Disciplinary Commission must be licensed medical or osteopathic physicians and there are no public members. The Board began publishing notices of its meetings in 1979. Generally, the public does not attend Board meetings and has made no input to the Board concerning its policies and decisions.

RECOMMENDATION

PUBLIC MEMBERS SHOULD BE ADDED TO THE BOARD AND TO THE DISCIPLINARY COMMISSION.

Administration

The Audit Council reviewed Board records, files, and operational procedures and found several areas for improvement in the Board's administration.

The Council found a need for better control over the Board's property. Inventory records should be updated and the personal property of the building's owner should be clearly delineated from the Board's property.

The Board needs a better method of budgeting or differentiating between the cost of personal services, inventory, utility costs, and other expenses shared with the Board of Dentistry. Both agencies share staff, space and equipment. Costs incurred should be accurately and fairly portrayed in order for the State and the agency's budgetary and planning process to be as accurate as possible.

RECOMMENDATIONS

THE BOARD OF MEDICAL EXAMINERS SHOULD DEVELOP A BETTER INVENTORY CONTROL SYSTEM.

THE BOARD SHOULD DEVELOP A DETAILED METHOD OF CALCULATING AND ALLOCATING SHARED COSTS WITH THE BOARD OF DENTISTRY.

SUNSET ISSUES AND EVALUATIONS

Act 608 of 1978, known as the Sunset Law, contains a series of eight issues which must be addressed in the review of each agency. These requirements encompass the areas of efficiency and effectiveness which will help determine the termination, continuation, or reestablishment of the agency and will also supply to the General Assembly an indication of the agency's public responsiveness and regulatory compliance. A summary of these issues and Audit Council's responses are presented in the following section.

(1) DETERMINE THE AMOUNT OF THE INCREASE OR REDUCTION OF COSTS OF GOODS AND SERVICES CAUSED BY THE ADMINISTERING OF THE PROGRAMS OR FUNCTIONS OF THE AGENCY UNDER REVIEW.

The programs and functions of the Board of Medical Examiners do not influence directly the cost of physicians' services in South Carolina. The cost of medical services to the public is determined by the individual physician.

(2) WHAT ECONOMIC, FISCAL AND OTHER IMPACTS WOULD OCCUR IN THE ABSENCE OF THE ADMINISTERING OF THE PROGRAMS OR FUNCTIONS OF THE AGENCY UNDER REVIEW?

The termination of the Board of Medical Examiners and the elimination of its regulation over the medical profession would

endanger the public's health, safety and welfare. The Board is needed to ensure that those who hold themselves out as physicians in South Carolina are qualified to do so. Without State licensure of doctors, the public may be exposed to unqualified or untrained practitioners.

In the absence of State regulation of physicians and physician assistants, it is likely the fiscal impact on the public would be grave. The public would probably suffer physically and economically from poor health care.

(3) DETERMINE THE OVERALL COSTS, INCLUDING MANPOWER, OF THE AGENCY UNDER REVIEW.

The overall cost of the agency in FY 78-79 was $244,933. Projected FY 79-80 expenditures are $269,189 (see p. 8).

(4) EVALUATE THE EFFICIENCY OF THE ADMINISTRATION OF THE PROGRAMS OR FUNCTIONS OF THE AGENCY UNDER REVIEW.

The Audit Council found that a few administrative improvements are needed, including a system of accounting for property inventory and a system of cost allocation to divide equitably administrative costs with the Board of Dentistry (see p. 36). In addition, the lack of investigative staff has caused the Board to fall behind in its complaint investigation (see p. 24). Also, the Board needs to revise its travel and per diem policies (see p. 32).

(5) DETERMINE THE EXTENT TO WHICH THE AGENCY UNDER REVIEW HAS ENCOURAGED THE PARTICIPATION OF THE PUBLIC AND, IF APPLICABLE, THE INDUSTRY IT REGULATES.

The general public does not participate in Board activities. By statute, all members of the Board and the Disciplinary Commission are medical and osteopathic physicians.

The Board has invited the input of the medical profession via questionnaires sent to doctors and also through its association with the SCMA. Announcements of its disciplinary actions are sent to medical societies and hospitals.

(6) DETERMINE THE EXTENT TO WHICH THE AGENCY DUPLICATES THE SERVICES, FUNCTIONS AND PROGRAMS ADMINISTERED BY ANY OTHER STATE, FEDERAL OR OTHER AGENCY OR ENTITY.

The Board's role in licensing, examining and disciplining physicians is not duplicated by any other State or Federal entity. Other agencies do conduct investigations of physicians upon occasion. For example, the Department of Health and Environmental Control investigates violations of controlled substances regulations. However, the Board of Medical Examiners can receive investigative reports from these agencies after they are completed and then make its own determination as to whether the physician should be disciplined. Therefore, the process is not duplicated.

(7) EVALUATE THE EFFICIENCY WITH WHICH FORMAL PUBLIC COMPLAINTS FILED WITH THE AGENCY CONCERNING PERSONS OR INDUSTRIES SUBJECT TO THE REGULATION AND ADMINISTRATION OF THE AGENCY UNDER REVIEW HAVE BEEN PROCESSED.

The Board of Medical Examiners processes public complaints efficiently and fairly. All formal complaints received by the Board receive at least a preliminary investigation to determine if they are valid. The Board keeps files on all public complaints showing whether they were dismissed or fully investigated, and what action was taken (see p. 21).

(8) DETERMINE THE EXTENT TO WHICH THE AGENCY UNDER REVIEW HAS COMPLIED WITH ALL APPLICABLE STATE, FEDERAL AND LOCAL STATUTES AND REGULATIONS.

The Board of Medical Examiners has complied with all applicable State and Federal regulations. However, some of its travel and administrative procedures are in need of improvement (see p. 32).

APPENDIX

APPENDIX 1

MEDICAL BOARD COMMENTS

Basically, the summary of the Sunset Issues and Evaluations of the Legislative Audit Council have some constructive criticism.

Prior to this audit the Board had already been working for some time on various areas such as: changing outdated rules; more detailed records; and increasing the Board's capacity for handling complaints, investigations, and final disposition of disciplinary cases.

With increased personnel the Board has been updating files containing more details, as are increasingly required by all of the various state agencies. The reference to per diem has been noted, and better background has been developed to more accurately account for these expenses. These expenses involve interviews, Board meetings and examinations, committee meetings, and many other areas which require a great deal of the Board members' time in the various areas of the Medical Board's business. The Board members' constant involvement is an obvious service to the public, the medical profession, and the state as a whole, as shown by the productivity reflected in the various charts throughout the report. The results are supported by the high quality of medical care available in the state of South Carolina.

The Board feels that the thorough screening of applicants including personal interviews are necessary and productive since physicians generally direct most of the medical health teams in the state.

In several instances legislative changes that were suggested in the Legislative Audit Council report had been attempted by the Board in the past, but they as yet have not been enacted into law.

The combined efforts with another similar agency provide more hours per week for better service to the public and the medical profession.

All expenses for this Board are paid from fees received from the members of the medical profession, as required and limited by law.

The past record of the Medical Board, without any major problems, and the continuously increasing licensing of qualified professionals speaks for itself. With limited budget and staff the Board continues to fulfill the purpose for which it was created.